MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

REQUEST BY A HEALTH CARE PROVIDER FOR CASE STATUS INFORMATION TO FILE A MEDICAL FEE DISPUTE APPLICATION

This form must be completed in its entirety for the Division to evaluate your request. Please state "unknown" if you are unable to complete any required field.

Health Care Provider Information

Name & Address	Contact Person Name Telephone No.

Employee Information

Name	Date of Accident/Occupational Disease	Date Service Provided
Social Security No.	Injured Body Part(s)	

Employer Information

Name	Address

Insurer Information

Name	Address

I am requesting the Division to provide the following information *(please check all that apply)*

☐ Injury No.	☐ Insurance Carrier

☐ Status Update

a. Report of Injury has been filed with the Division ☐ Yes ☐ No

b. Claim for Compensation has been filed with the Division ☐ Yes ☐ No

c. Date the case was Settled _____

d. Date the case was Dismissed _____

☐ Name and Address of Claimant's Attorney	☐ Name and Address of Employer/Insurer Attorney

Please return completed form with a self-addressed stamped envelope to:

Missouri Division of Workers' Compensation
Attn: Medical Fee Dispute Unit
P.O. Box 58
Jefferson City, MO 65102-0058

DIVISION USE ONLY

DATE STAMP